# Somatoform disorders

see also p 249

Mr X, a 68-year-old married Chinese man who is a retired cook, reports sleep disturbances with irritability and loss of appetite for the past 6 months. He has frequent headaches, dizziness, and a sensation of tightness in the chest.

Three weeks before this visit, he had several episodes of chest pain and went to the local hospital, where he was admitted for a medical evaluation. Results of all investigations, including tests for ischemic heart disease, were normal. He was referred for psychiatric consultation.

Despite sensitive probing by the psychiatrist, Mr X denies symptoms of anxiety and depression. He has no history of psychiatric or physical illness.

## SOMATOFORM DISORDERS IN THE PRIMARY CARE SETTING

Somatoform disorders are characterized by physical symptoms that suggest a physical disorder but for which there are no demonstrable organic causes or known physiologic mechanisms.[1] The symptoms are not under voluntary or conscious control; the patient is not malingering. Patients with these disorders make persistent requests for medical investigations, although all findings are negative and

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## Summary points

- Somatoform disorders are characterized by bodily symptoms suggestive of a physical disorder but for which there are no demonstrable organic causes or known physiologic mechanisms
- Patients with such disorders persistently request medical investigations despite reassurances by physicians that their symptoms have no physical basis
- Traditional Chinese medicine has no concept of "medically unexplained symptoms"
- Treatment may be less complicated in Asian patients than in white patients because Asian patients recognize an interconnection between mind and body
- Because Asian patients may not report anxiety or depression, which often coexist with somatoform disorders, these disorders may go unrecognized

health care providers repeatedly determine there is no physical basis for the symptoms.

The different types of somatoform disorders are shown in box 1.

## DIFFERENTIAL DIAGNOSIS

When a patient reports symptoms that cannot be explained by an underlying organic problem, the primary care provider should consider psychiatric disorders, such as major depression, anxiety disorders, and alcohol and drug abuse, in the differential diagnosis (see box 2).[2]

Somatoform disorders can coexist with other psychiatric conditions.

### Box 1 Types of somatoform disorders

**Somatization disorder** Usually begins before age 30, extends over a period of years, and is characterized by a combination of pain, gastrointestinal, sexual, and neurologic symptoms

**Somatoform pain disorder** The main complaint is pain that causes distress or impairment in functioning and in which psychological factors are judged to play a role

**Conversion disorder** A loss or change in sensory or motor function (eg, a hemiparesis) that is suggestive of a physical disorder but is caused by psychological factors

**Hypochondriasis** Preoccupation with and conviction of having a serious disease, even after appropriate medical evaluation and reassurance of good health. Patients either have abnormal concerns about a normal or minor symptom or amplify a minor symptom to major proportions

**Body dysmorphic disorder** Preoccupation with an imagined or exaggerated defect in physical appearance

**Undifferentiated somatoform disorder** One of the most common, it is characterized by unexplained physical complaints of at least 6 months duration that are below the threshold for a diagnosis of somatization disorder. It is close to the concept of neurasthenia (see p 257), a widely held illness belief among Chinese patients.

### Box 2 The differential diagnosis of somatoform disorders

**Depression with somatoform complaints** This condition is far more common than somatoform disorders and differs in that patients present with dysphoric mood or loss of pleasure (anhedonia), accompanied by secondary somatic symptoms (insomnia, fatigue, anorexia, weight loss). Treating the underlying depression helps both the affective and somatic symptoms.

**Anxiety disorders** (see p 249).

**Substance abuse disorders** Alcohol abuse should be considered in patients with multiple somatic complaints. Heavy alcohol users may complain of insomnia, morning cough, pain in the extremities, dysesthesias (painful sensations induced by a gentle touch of the skin), palpitations, headaches, gastrointestinal symptoms, fatigue, and easy bruising.

**Psychotic disorders** Somatic delusions of schizophrenia are generally bizarre and idiosyncratic (eg, pain shooting up the spine and out the ears). Patients usually have other coexisting psychotic symptoms, such as hallucinations and paranoid delusions, and their overall level of function is generally worse than that of patients with somatoform disorders.

**Personality disorders** Patients have an enduring pattern of behavior that deviates from the expectations of the individual's culture, is pervasive and inflexible, and leads to distress or impairment.

**Malingering disorder** This disorder represents one type of voluntary symptom production. The patient lies about the presence or severity of symptoms to serve an obvious goal or purpose. Clues to the diagnosis include a connection between the patient's symptoms and a medicolegal issue, a discrepancy between the patient's subjective distress and objective findings, and the coexistence of antisocial personality disorder. An example is a patient who feigns illness to receive medical disability payments.

**Factitious disorder (Munchausen's syndrome)** Voluntary symptom production associated with this disorder shows no apparent self-advantage and often is self-destructive. The motivation is usually psychological gain, which is not apparent even to family and friends, as opposed to overt gains, such as economic advantage or avoidance of incarceration. An example is a patient with a fever of unknown origin in whom all test results are normal and who has no apparent gain from having the illness. The patient is later discovered to have created bacteremia by injecting herself with fecal material, continuing a lifelong pattern of dependency on others and the need to cultivate the sick role when her relationships are failing. These patients often have borderline personality disorder.

- Two thirds of patients with somatization disorder (a type of somatoform disorder) have symptoms of other psychiatric disorders, and one third meet the criteria for at least one other psychiatric diagnosis
- Anxiety disorders are common among patients with hypochondriasis
- Personality disorders can coexist with somatoform disorders

Treating a condition that coexists with a somatoform disorder, such as coexistent anxiety and depression, can alleviate symptoms of the somatoform disorder.[3]

## DIAGNOSIS

The absence of organic findings to explain patients' reported symptoms suggests the possibility of a somatoform disorder. Usually, the complaints tend to be chronic and recurrent and fluctuate corresponding to psychosocial factors.

These complaints are common among Asian patients, but they usually do not satisfy the stringent criteria for somatization disorder. Following formal *DSM-IV* classification, many patients with such complaints can be categorized as having undifferentiated somatoform disorder. The most common of these symptoms in Asian patients include insomnia, headache, failure to concentrate, and symptoms of anxiety and depression.[4]

It is important to rule out underlying mood or anxiety disorders, which should be treated accordingly. Many Asian patients with anxiety and depression tend to selectively report their physical symptoms and underreport their mood symptoms because they consider anxiety and depression normal responses to life stresses and not symptoms of distinct disorders. They may also consider that mood symptoms are not relevant when they see their medical practitioner.

To assess Asian patients with medically unexplained symptoms, we find it helpful to:

- Accept their somatic symptoms
- Actively inquire about mood
- Explore their psychosocial background
- Screen for anxiety and depressive disorders, substance abuse, and psychotic symptoms

When needed, referral to medical consultants should be directed to those who order tests conservatively, are experienced with somatization disorders, and can collaborate with primary care physicians.

## MANAGEMENT AND TREATMENT

### Primary care approach

When managing and treating somatoform disorders in Asian patients, the primary care practitioner should take the following steps:

- Show a genuine interest in the reported somatic symptoms. Inquire about their onset, characteristics, location, duration, and exacerbating and relieving factors. Find out how the symptoms affect the patient, what treatment has been attempted, and whether or not it was effective.
- Rule out concurrent physical disorders
- Be nonjudgmental, respectful, and empathetic. Listening with patience is more important than attempting to provide a quick fix.
- Establish a supportive relationship. Inform patients that these symptoms tend to run a long course and may fluctuate according to changing psychosocial situations.
- Treat coexisting psychiatric disorders
- Provide medications for supportive treatment, such as analgesics for pain and headache, antispasmodics and antacids for abdominal discomfort, and short-term hypnotics for insomnia (being careful not to encourage dependence). These prescriptions are welcomed for symptom relief and as a sign of acceptance of the symptoms. Antidepressants may be effective for treating somatoform disorders even when there is no coexisting depressive disorder.[5]
- Allow patients to participate in decisions regarding the choice of treatment. This involvement encourages them to follow recommendations more closely.
- Encourage rehabilitation treatment, including exercise, physical therapy, yoga, tai chi, and participation in social activities
- Inform patients that improvement of their symptoms can depend on how much they alter their lifestyles, and that it is their responsibility to do this. Common problems include poor sleep patterns, inability to set limits on personal goals and on demands from other people, lack of assertiveness, inadequate social skills, and inability to set priorities in life. Patients should be encouraged to seek professional help when needed.
- Explore relationships in the patient's family and at work and whether significant life events have occurred. Questions such as. "What is going on in your family?" or "How is work?" may reveal important information. Listen to the emotional tone when the patient responds to the questions.
- Look for possible relationships between what is happening in the patients' lives and their symptoms and help them see the connection
- Refer patients for psychological intervention to address their current life events as well as interpersonal conflicts. Many Asian patients benefit from such intervention and from learning communication as well as coping skills.

When asked about his family, Mr X reports that his wife had worked for many years as a nanny in a distant town and they were accustomed to living apart. She retired 6 months ago and returned to live with him. He became animated and agitated when talking about his wife and described her as a headstrong woman who always did things her way. The psychiatrist pointed out to him that his symptoms might be related to his recent life changes because they started when his wife rejoined him.

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Tai chi chuan can be part of the rehabilitation treatment for patients with somatoform disorders

Mr X was later able to tell the psychiatrist that his symptoms got worse when his wife aggravated him. They fought frequently about everything from how to set up a monthly budget to arranging their furniture, to what gifts to send to their children. He remembered that before he went to the emergency department at the hospital, he was angry with his wife because "she put wet dishes in the wrong place and messed up the kitchen."

### Referral to a mental health specialist

Psychiatric consultation is *useful* for the evaluation of:

- Psychotic symptoms
- Suicidal or homicidal tendencies
- The need for involuntary hospitalization
- The need for medication and psychological treatments

Psychiatric consultation is *essential* in patients with suspected factitious disorder (Munchausen's syndrome) to obtain help in detecting methods of self-induced symptoms and exploring underlying psychologic pathology.[6]

### Traditional Chinese medicine (TCM) approach

Asian patients with somatoform disorders may have visited a practitioner of TCM. It is helpful to be aware of this care, to know what was recommended, and to consider incorporating TCM approaches into the treatment plan.

Western medicine relies heavily on laboratory tests; TCM does not. Consequently, "medically unexplained symptoms" do not exist in TCM. Diagnosis in TCM is based on four techniques (observing, listening and smelling, asking, and feeling the pulse) and four types of pathologic change (*Qi* (air), blood, *yin-yang*, or an organ inside the body). Using the four techniques, TCM practitioners collect information on the possible pathologic changes that could explain patients' symptoms and would allow them to provide treatment to alleviate the symptoms.

Whereas the mind and body are considered separate entities in Western medicine, mind and body are integrated and inseparable in TCM. Accordingly, any change of the mind will inevitably affect the body and vice versa. Psychological problems are frequently considered the causes of physical disorders. Emotions (eg, joy, anger, worry) are "internal etiologies" and lifestyle and circumstances (eg, eating, working, accidents) are "external etiologies" of diseases. Longstanding and intense emotional stress is thought to upset the homeostasis of the body and disrupt the ability of the body to maintain the normal functions of *Qi*, blood, and organs; disease is the result. Indulgent lifestyles, such as eating unhealthy diets, overeating, overworking, and excessive sexual activity, are thought to damage organ function.

TCM treatment of somatoform disorders includes herbal medicine, acupuncture, *Tuina* massage, and *qigong*. One or more of these methods are used. Practitioners of TCM generally consider the patient's preference when deciding which treatment to use.

Mr X was encouraged to release his frustration and anger toward his wife during his visits to his practitioners. The psychiatrist explained the relationship between Mr X's frustrations and his physical symptoms and pointed out that spouses who do things differently could still work together. The psychiatrist helped Mr X learn how to communicate his ideas and opinions to his wife and to take turns in making decisions. After four visits, Mr X's coping skills had improved, and he reported less frustration and anger and fewer physical symptoms. He thought he was able to end treatment.

References

1 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.* Washington, DC: American Psychiatric Association; 1994:219-228.
2 Calabrese LV. Approach to the patient with multiple physical complaints. In: Stern TA, Herman JB, Slavin PL, eds. *The Massachusetts General Hospital Guide to Psychiatry in Primary Care.* New York: McGraw-Hill; 1998:89-98.
3 Barsky A, Stern TA, Greenberg DB, Cassem NH. Functional somatic symptoms and somatoform disorders. In: Cassem NH, Stern TA, Rosenbaum JF, Jellinek MS, eds. *Massachusetts General Hospital Handbook of General Hospital Psychiatry.* 4th ed. St Louis: Mosby-Year Book; 1997:305-336.
4 Lee S. A Chinese perspective of somatoform disorders. *J Psychosom Res* 1997;43:115-119.
5 Fishbain D. Evidence-based data on pain relief with antidepressants. *Ann Med* 2000;32:305-316.
6 Engel CC., Katon WJ. Somatization. In: Noble J, ed. *Textbook of Primary Care Medicine.* 2nd ed. St Louis: Mosby-Year Book; 1996.